STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	10/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/01/19 through 10/04/19. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):]	E 015		11/19/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/29/2019

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E 015	Continued From page 1 Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on record reviewed staff interview, the facility staff failed to have a Fire watch Program as a component of the Emergency Preparedness fire Detection Plan. The findings included: During an review of the facility's Emergency Preparedness Plan at 11:50 AM on 10/03/19 with the Administrator he stated, the "Facility had in place a Fire Watch Program for fire detection. The Administrator was asked for documentation that the Fire Watch Program was included in the Emergency Preparedness Program. The Administrator stated, he did not have a Fire Watch Program but could get one. When asked had staff been trained on a Fire Watch Program	E 015	1. Saber Fire Watch Policy added to EPP. 2. All residents at risk. 3. Education of all staff on Fire Watch Policy and policy education added to orientation and annual EPP training. 4. Monthly audits x3 months by Admin. or designee of employee files to ensure education conducted. Audit results will be reviewed in QAPI. 5. 11/18/19	

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E 015	Continued From page 2 he stated, the staff would be trained when the Fire Watch needed to be put in place. The facility staff failed to develop a Fire Watch Program for Fire Detection as a part of the facility's Emergency Preparedness Program.	E 015		
E 031 SS=C	Emergency Officials Contact Information CFR(s): 483.73(c)(2) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced	E 031		11/18/19

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E 031	Continued From page 3 by: Based on record review and staff interview, the facility staff failed to have in their communication plan all facility contact and contact information for the following: Federal, State, tribal, regional and local emergency preparedness staff. The findings included: During an interview on 10/3/19 at 12:50 P.M. with the administrator, he was asked for the names and contact information for all facility staff, as well as entities providing services under agreement during an emergency. A review of the communication plan did not include the name of all staff and their contact information. Nor did the plan include the contact information for Federal emergency preparedness staff.	E 031	1. A. FEMA Contact information added to EPP. B. Contact information on all staff provided on staff roster in EPP. 2. All residents at risk. 3. A. & B. EPP will be audited quarterly by Admin. or designee x6 months to ensure FEMA contacts and staff information is current. 4. Admin. or Designee will review EPP FEMA contacts and staff information annually. Audit results will be reviewed in QAPI. 5. 11/18/19	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/1/19 through 10/4/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code Report to follow. No complaints were investigated during the survey. The census in this 108 certified bed facility was 103 at the time of the survey. The survey sample consisted of 39 resident reviews (35 current resident reviews and 4 closed record reviews).	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:	F 557		11/18/19

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F 557	Continued From page 4 §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, it was determined that the facility failed to replace personal property damaged by facility laundry for one resident out of 39 records reviewed. The findings included: Resident #32 was initially admitted to the facility on 6/6/2016 with most recent admission occurring on 4/26/2019 with diagnoses of, but not limited to, chronic pain syndrome and epilepsy. Resident #32's most recent MDS (minimum data set) assessment was a quarterly review assessment with an ARD (assessment reference date) of 7/21/19. Resident #32 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (brief interview for mental status) exam. The resident was assessed to have clear speech and no impairments in understanding others. Resident #32 was assessed at requiring extensive support with dressing and personal hygiene. An interview conducted on 10/2/2019 at approximately 12:37 p.m. with Resident #32 who reported two of her clothing items returned from the laundry, bleached. An interview was conducted on 10/2/2019 at	F 557	1. Personal Property of resident #32 replaced. 2. Facility population audited for any similar incidents by Social Worker. 3. Laundry staff educated by Laundry supervisor on proper handling of residents clothes during laundering. 4. Social Worker will audit facility population monthly x3 months for incidents of facility damaged resident clothing. Audit results will be reviewed in QAPI. 5. 11/18/19	

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F 557	Continued From page 5	F 557		

approximately 3:30 p.m. with Other Staff # 3, the social worker, regarding complaints from Resident #32 and damaged clothing. The social worker stated "(Resident #32) will usually speak with the unit manager. Residents are supposed to complete grievance forms. A lot of grievances don't make it to me. I don't have any grievances from (Resident #32). She stated she would see housekeeping about this.

An interview was conducted on 10/2/2019 at approximately 3:50 p.m. with the Housekeeping Director, Other Staff #2, regarding Resident #32's damaged clothing concern. The Housekeeping Director stated "She had clothes that were faded. The facility was going to replace them. I took it to the administrator, Activities was supposed to go out shopping to replace them."

An interview conducted on 10/2/2019 at approximately 3:56 p.m. with the Activities Director, Other Staff #1, regarding Resident #32's damaged clothing. The Activities Director stated "The sister was out of town and we could not go out. Her sister was supposed to pick out the outfit. Activities actually pays for it. I never had a chance to discuss it with her sister."

An interview conducted on 10/3/2019 at approximately 11:00 am with the facility Administrator regarding Resident #32's damaged clothing. The Administrator stated "We came to an agreement about the clothes that were bleached. The sister would come in and pick them out for her. The sister went out of town and we weren't able to get her clothing. We have no policy regarding damaged property."

The Facility Administrator provided a copy of the

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F 557	Continued From page 6 Concern Form dated 7/17/2019 regarding damaged clothing offering a resolution of replacement of damaged items at Facility's expense. No further information was provided by the facility staff.	F 557		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interviews, the facility's staff failed to assure 1 of 39 residents (Resident #59), in the survey sample call bell was within reach at all times. The findings included: Resident #59 was originally admitted to the facility 2/5/18 and has never been discharged from the facility. The current diagnoses included, left sided hemiplegia (paralysis). The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/27/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #59 cognitive abilities for daily decision making were intact. In section "G" (physical functioning) the resident was coded as requiring extensive assistance of two people with transfers and toileting, extensive assistance of	F 558	1) Residents call bell was placed within reach of the resident and present staff educated on “resident specific” positioning of call light 2) All residents that require any assistance have the potential to be affected by this deficiency 3) In service education by the DON or designee on correct placement of call bell specific to the individual needs of the resident to be conducted 4) Random weekly audits by the unit mgrs or designee X 3 months to ensure correct placement of call lights. Results to be discussed at QAPI and daily in cases of non-compliance 5) 11/18/19	11/18/19

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F 558	Continued From page 7	F 558		

one person with bed mobility, dressing and personal hygiene and total care of one person bathing and locomotion.

One 10/1/19 at approximately 12:30 p.m., the resident was observed seated in a wheelchair close to the foot of the bed with the lunch meal on the table before her. She called out "I need my pan because I throw up a lot." The resident was referring to a gray bathing basin sitting on her bed out of her reach. The resident was reminded to press her call bell which was attached to the foot of her bed on the resident's left side. The resident's left arm and hand had no movement therefore she attempted to reach across her body to press the call bell with her right hand and arm but she was unable to reach it after putting much effort into the task. Certified Nursing Assistant (CNA) #2 was notified the resident needed assistance and was observed handing the resident the requested basin but the call bell was not placed in a reachable place.

On 10/2/19 at approximately 12:40 p.m., Resident #59 was observed again seated in a wheelchair near the foot of the bed. The call bell was observed midway on the bed which was to her left.

On 10/2/19 at approximately 12:45 p.m., an interview was conducted with Licensed Practical Nurse (LPN) #2 about the location of the resident's call bell as it was placed. LPN #2 stated "No she can't reach it as placed because she can't reach that far." LPN #2 attached the call bell to the front of Resident #59 shirt, where she could easily reach it when needed.

On 10/3/19, at approximately 6:00 p.m., the

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F 558	Continued From page 8 above findings were shared with the Director of Nursing and the Corporate Consultant. The Director of Nursing stated the resident is with left hemiplegia and is unable to reach items on her left beyond the right hands reach and staff would be asked to ensure all residents can each their call bell based on their capabilities.	F 558		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and	F 604		11/18/19

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F 604	Continued From page 9 document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility staff failed to ensure one of 39 residents in the survey sample, Resident #68, was free from physical restraints. The facility staff had tube socks in use to Resident #68's bilateral arms to prevent scratching of a wound. The findings included: Resident #68 was re-admitted to the facility on 09/13/19 with diagnoses that included, but not limited to, dementia, Type 2 Diabetes mellitus without complications, dementia, depression, sepsis, osteomyelitis of vertebra, sacral and sacrococcygeal region. A Quarterly Minimum Data Set (MDS) dated 09/04/19 assessed Resident #68 Brief Interview for Mental Status (BIMS) a score of 6 which indicated severe cognitive impairment. In the area of Functional Status this resident was assessed in the area of Activities of Daily Living (ADL'S) as requiring total dependence of two persons for bed mobility and toileting. Extensive assistance of one person physical assist for dressing and personal hygiene. In the area of Bladder and Bowel this resident was assessed as requiring an Indwelling Catheter. A Care Plan dated 09/16/19 indicated: Focus-Resident #68 is at risk for impaired skin integrity R/T impaired mobility, bed/chair confined, F/C (Foley catheter) use, bowel incontinence, psychotropic med use, Underlying Disease, dementia, depression, DM, PVD, COPD, H/O,	F 604	1) The staff present that day were immediately educated on no restraint policy with signature sheet. LPN #6 educated 1 on 1 by DON on no restraint policy and when restraints are appropriate Resident was observed with no socks on arms at the time we learned of this. 2) All residents without the ability to remove the item restricting movement have the potential to be affected by this. (Please note that the resident upon assessment was able to take the socks off with minimal difficulty) 3) In-service education by the DON or designee on the use of restraints and the definition of what is considered a restraint to be completed with staff as well as new hires to receive more thorough training on restraints during orientation. 4) Random Weekly audits by the unit mgrs or designee to check for restraints to be performed X90 days. Results to be discussed at QAPI and daily in cases of non-compliance 5) 11/18/19	

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F 604	Continued From page 10	F 604		

CVA with left side weakness. Goal- residents skin will be free of further breakdown through next review. Resident re-admitted with open wounds to sacrum, right hip, right medical shin, and left hip. Open wounds on 09/24/19 to right lateral 3rd toe (healed 10/1/19) and right medial 4th toe. Resident noted with wound vac due to multiple areas of skin impairment with deterioration.

On 10/01/19 at 12:45 PM Resident #68 was observed in bed with a pair of tube socks on both hands extending up his arms. This resident was observed again on 10/01/19 at 2:30 PM in bed with a pair of tube socks on both hands extending up his arms. This resident was observed on 10/02/19 at 8:53 AM in bed with a pair of tube socks on both hands extending up his arms.

A review of the clinical records did not include a physician's order for the use of tube socks, nor did Resident #68's care plan include measures for how the tube socks would be used to treat the resident's scratching.

During an interview on 10/03/19 at 3:20 P.M. with LPN #6 (Licence Practical Nurse) she stated, "Resident #68 scratches the wound on his wound vac and some times pulls the wound vac out." During an interview on 10/04/19 at 11:15 A.M. with the Director of Nursing (DON) he was asked if Resident #68 had a physician's order for the use of the tube socks. The DON stated, Resident #68 did not have a physician's order for the use of tube socks. There was no restraint assessments for the use of the socks, no interventions for the treatment of itching or scratching behaviors and no alternate methods attempted prior to the use of the tube socks.

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F 622	Continued From page 11	F 622		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to §	F 622		11/18/19

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F 622	Continued From page 12 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information	F 622		

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F 622	Continued From page 13 (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to send the required documentation upon transfer to the hospital for two of 39 residents in the survey sample, Resident #33 and #26. The findings include: 1. Resident #33 was admitted to the facility on 6/2/17 and readmitted on 9/2/19 with diagnoses that included but were not limited to, major depressive disorder, bipolar disorder, high blood pressure, and type two diabetes. Resident #33's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 7/25/19. Resident #33 was coded as being moderately impaired in cognitive function scoring 11 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #33's clinical record revealed that Resident #33 was transferred to the hospital on 8/27/19. The following note was documented: "8/27/2019 14:36 (2:36 p.m.) SBAR "S" Situation: Change in condition, symptoms or signs I am calling about is/are: Abnormal vital signs (low/high	F 622	1) Nursing staff were immediately educated on the correct documentation required when sending a resident out with emphasis on Bed Hold agreement and Care Plan Goals and the documentation needed that items were sent. 2) Any resident with the potential to be sent out to the hospital has the potential to be affected by this deficiency 3) In-service education by the DON or designee on the proper transfer documents to send with residents and the proper documentation to verify sent items. 4) Audit of all transfers to the hospital to ensure needed documents and verification of sent documents by DON or designee on all transfers X90 days. Audit results to be reviewed in QAPI. 5) 11/18/19	

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BP, heart rate, respiratory rate, weight change) Altered mental status This started on 08/27/2019 and the time of day Afternoon...Send to E.D. (emergency department) for evaluation."

There was no evidence in Resident #33's clinical record that care plan goals were sent with Resident #33 upon transfer to the hospital.

Further review of Resident #33's clinical record revealed she arrived back to the facility on 9/2/19 with diagnoses of pneumonia.

On 10/3/19 at 12:34 p.m., an interview was conducted with RN (Registered Nurse) #1, the Assistant Director of Nursing. When asked what documents were sent out with a resident upon transfer to the hospital, RN #1 stated that nurses send the face sheet, SBAR note, bed hold policy, care plan and orders. When asked how to know what items were sent with a resident upon transfer, RN #1 stated that nurses should fill out a transfer check list that will list every item. When asked if that checklist included the care plan, RN #1 stated that it did. When asked if a checklist could not be found how to know that the care plan was sent with the resident, RN #1 stated that sometimes the nurses will document a note.

On 10/4/19 at 10:46 a.m., during the pre-exit meeting, ASM (administrative staff member) #1, the administrator, ASM #2, the Director of Nursing and ASM #3, the Regional Director of Clinical Services were made aware of the above concerns. ASM #3 stated that she would try to find evidence that care plan goals were sent with Resident #33 at the time of transfer.

On 10/4/19 at approximately 11:30 a.m., ASM #3

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F 622	Continued From page 15	F 622		

stated that she could not find evidence that care plan goals were sent with Resident #33. No further information was provided prior to exit.

2. Resident #26 was admitted to the facility on 6/4/12 with diagnoses that included but were not limited to dementia without behavioral disturbance, high cholesterol, type two diabetes and adult failure to thrive. Resident #26's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 7/16/19. Resident #26 was coded as being severely impaired in cognitive function scoring 04 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #26's clinical record revealed that she was had a fall on 9/3/19 and was transferred to the hospital.

Review of Resident #26's INTERACT check list failed to evidence that care plan goals were sent with Resident #26 at the time of transfer.

On 10/3/19 at 12:34 p.m., an interview was conducted with RN (Registered Nurse) #1, the Assistant Director of Nursing. When asked what documents were sent out with a resident upon transfer to the hospital, RN #1 stated that nurses send the face sheet, SBAR note, bed hold policy, care plan and orders. When asked how to know what items were sent with a resident upon transfer, RN #1 stated that nurses should fill out a transfer check list that will list every item. When asked if that checklist included the care plan, RN #1 stated that it did. When asked if a checklist could not be found how to know that the care plan

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F 622	Continued From page 16 was sent with the resident, RN #1 stated that sometimes the nurses will document a note. On 10/4/19 at 10:46 a.m., during the pre-exit meeting, ASM (administrative staff member) #1, the administrator, ASM #2, the Director of Nursing and ASM #3, the Regional Director of Clinical Services were made aware of the above concerns. ASM #3 stated that she would try to find evidence that care plan goals were sent with Resident #26 at the time of transfer. On 10/4/19 at approximately 11:30 a.m., ASM #3 stated that she could not find evidence that care plan goals were sent with Resident #26. No further information was provided prior to exit.	F 622		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1)	F 625		11/18/19

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F 625	Continued From page 17 of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that facility staff failed to send written bed hold notification upon transfer to the hospital for one of 39 residents in the survey sample, Resident #33. The findings include: Resident #33 was admitted to the facility on 6/2/17 and readmitted on 9/2/19 with diagnoses that included but were not limited to major depressive disorder, bipolar disorder, high blood pressure, and type two diabetes. Resident #33's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 7/25/19. Resident #33 was coded as being moderately impaired in cognitive function scoring 11 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #33's clinical record revealed that Resident #33 was transferred to the hospital on 8/27/19 for a change in condition. There was no evidence in Resident #33's clinical record that written bed hold notification was sent with Resident #33 upon transfer to the hospital.	F 625	1) Nursing staff were immediately educated on the correct documentation required when sending a resident out with emphasis on Bed Hold agreement. 2) Any resident with the potential to be sent out to the hospital has the potential to be affected by this deficiency 3) In-service education by the DON or designee on the proper transfer documents such as the Bed Hold Agreement to send with residents and the proper documentation to verify sent items 4) Audit of all transfers to the hospital to ensure needed documents and verification of sent documents by DON or designee on all transfers X90 days. Audits reviewed in QAPI. 5) 11/18/19	

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Further review of Resident #33's clinical record revealed she arrived back to the facility on 9/2/19 with diagnoses of pneumonia.

On 10/01/19 at 2:56 p.m., an interview was conducted with Resident #33. Resident #33 could not recall anyone going over the written bed hold notice at the time of her transfer. Resident #33 could not recall receiving any information regarding bed hold. Resident #33 stated that she was able to go back to her room once admitted back to the facility.

On 10/3/19 at 12:34 p.m., an interview was conducted with RN (Registered Nurse) #1, the Assistant Director of Nursing. When asked what documents were sent out with a resident upon transfer to the hospital, RN #1 stated that nurses send the face sheet, SBAR note, bed hold policy, care plan and orders. When asked how to know what items were sent with a resident upon transfer, RN #1 stated that nurses should fill out a transfer check list that will list every item. When asked if that checklist included the bed hold notification, RN #1 stated that it did. When asked if a checklist could not be found how to know that the bed hold notice was sent with the resident, RN #1 stated that sometimes the nurses will document a note.

On 10/4/19 at 10:46 a.m., during the pre-exit meeting, ASM (administrative staff member) #1, the Administrator, ASM #2, the Director of Nursing and ASM #3, the Regional Director of Clinical Services were made aware of the above concerns. ASM #3 stated that she would try to find evidence that the written bed hold notice was sent with Resident #33 at the time of transfer.

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F 625	Continued From page 19 On 10/4/19 at approximately 11:30 a.m., ASM #3 stated that she could not find evidence that written bed hold notice was sent with Resident #33. No further information was provided prior to exit. Facility policy titled, "Bed Hold Letter Policy," did not address the above concerns.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to ensure an accurate MDS (minimum data set) assessment for two of 39 residents in the survey sample, Residents # 102 and #59. The findings include: Resident #102 was admitted to the facility on 7/17/19 with diagnoses that included but were not limited to, type 2 diabetes, atrial fibrillation, high blood pressure and muscle weakness. Resident #102's most recent MDS (minimum data set) assessment was a discharge, return not anticipated, assessment with an ARD (assessment reference date) of 8/2/19. Resident #102 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Further review of Resident #102's MDS coded Resident #102 in Section A2100. "Discharge	F 641	1. Resident #102 MDS was modified to reflect he was discharged to home. Resident #59 MDS was modified to reflect deep tissue wound to left heel is current. 2. Audit on all discharges in last 6 months by MDS Coordinator to ensure D/C status is accurate. Audit on all residents with MDS wound assessments in last 6 months by MDS Coordinator to ensure wound status is accurate. 3. MDS's audited monthly for accuracy. 4. Audit results will be reviewed in QAPI. 5. 11/18/19	11/18/19

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Status," as being sent to the hospital.

Review of Resident #102's August 2019 nursing notes revealed the following notes:
"8/2/19 at 08:52 a.m.: (Name of Resident #102) will discharge home with (Name of home health). Transport will pick up at 10:45 a.m.
8/2/19 at 9:41 a.m. Reviewed all discharge paperwork and medications with resident. Answered all questions and concerns. Resident voiced understanding.
8/2/19 at 14:56 (2:56 p.m.) Resident discharged from facility at 10:30 (a.m.) with medical transport via wheel chair."

On 10/3/19 at 9:38 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #3, the MDS nurse. When asked the process for filling out Section A2100., LPN #3 stated that prior to filling out Section A2100, she would search the Resident's chart and find out how the resident was discharged (i.e. hospitalized, sent home, death). LPN #3 stated she would then code section A2100 accordingly. LPN #3 confirmed that Resident #102 was discharged and home and that his 8/2/19 MDS assessment was coded in error. LPN #3 stated that she would modify the MDS.

On 10/4/19 at 10:46 a.m., during the pre-exit meeting, ASM (administrative staff member) #1, the Administrator, ASM #2, the Director of Nursing and ASM #3, the Regional Director of Clinical Services were made aware of the above concerns. No further information was presented prior to exit.

CMS' RAI Version 3.0 Manual (Chapter 1: Resident assessment Instrument (RAI)

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"A2100: OBRA Discharge Status
Review the medical record including the discharge plan and discharge orders for documentation of discharge location.
Coding Instructions: Select the 2-digit code that corresponds to the resident's discharge status.
·Code 01, community (private home/apt., board/care, assisted living, group home): if discharge location is a private home, apartment, board and care, assisted living facility, or group home.
·Code 02, another nursing home or swing bed: if discharge location is an institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care or rehabilitation services for injured, disabled, or sick persons. Includes swing beds.
·Code 03, acute hospital: if discharge location is an institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled, or sick persons..."

2. Resident #59 was originally admitted to the facility 2/5/18 and has never been discharged from the facility. The current diagnoses included; left hemiplegia and a left heel pressure ulcer.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/27/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #59 cognitive abilities for daily decision making were intact. In section "G"

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(Physical functioning) the resident was coded as requiring extensive assistance of two people with transfers and toileting, extensive assistance of one person with bed mobility, dressing and personal hygiene and total care of one person bathing and locomotion. In section "M0300G1" the resident was coded as not having a suspected deep tissue injury to the left heel between 8/21/19 and 8/27/19.

On 10/3/19 at approximately 11:00 a.m., Resident #59 wound care to the left heel was observed. The heel wound was now opened measuring approximately 3 centimeters by 2 centimeters and 0.1 centimeters deep. It contained dark brown to black tissue in the center and the surrounding tissue was red and the outer tissue was with areas of white tissue. The resident expressed it wound was painful to touch but insisted the staff complete the care.

At approximately 1:20 p.m., an interview was conducted with the wound care nurse. She stated Resident #59's was observed by staff with a blister to her left heel on 7/22/19, but when she assessed the left heel on 7/23/19, a blister wasn't present but the left heel was with a 5 centimeter by 5 centimeter maroon color area and the skin was intact. The wound care nurse stated she classified the left heel wound as an unstageable deep tissue injury. The wound care nurse stated on 8/20/19 the wound care physician began management of the resident left heel pressure ulcer and on 8/27/19 the area remained an unstageable deep tissue injury per the wound care physician's progress note dated 8/27/19. The wound care nurse viewed Resident #59's MDS assessment at "M0300G1" which was coded the resident didn't have an unstageable

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F 641	Continued From page 23 deep tissue injury present. The wound care nurse stated this is not coded correctly. On 10/3/19 at approximately 3:05 p.m., an interview was conducted with the MDS Coordinator about the coding of Resident#59's 8/27/19, MDS assessment at "M0300G1." The MDS Coordinator stated it wasn't coded correctly therefore the MDS had been modified at to reflect at that time the resident did have unstageable deep tissue injury. The copy of the modified MDS assessment was given to the survey team. On 10/3/19, at approximately 6:00 p.m., the above findings were shared with the Director of Nursing and the Corporate Consultant. The Director of Nursing stated he was aware of the error and no additional information was provided.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 657		11/18/19

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F 657	Continued From page 24 and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility staff failed to revise the comprehensive care plan for two of 39 residents in the survey sample, Resident #23 and Resident #68. The findings included: For Resident #23, the facility staff failed to include a focus, interventions, or goals for inappropriate sexual comments/requests made to staff. Resident #23 was admitted to the facility on 07/11/16 with diagnoses that included hypertension, contractures of left hip, sleep disorder, anxiety disorder, major depression and osteoporosis. An annual Minimum Data Set (MDS) dated 07/14/19 assessed this resident in the area of Cognitive Patterns as scoring a 14 on the Brief Interview for Mental Status (BIMS) assessment which indicated intact cognition. In the area of Mood this resident was assessed as feeling down, depressed or hopeless. In the area of Functional Status Activities of Daily Living (ADL's) this resident was assessed as requiring total	F 657	1) Resident #23 care plan updated to address inappropriate sexual comments. Resident #68 identified as not having tube sock on his hands. Resident #68 care plan was updated to include intervention to protect wound from scratching. 2) Any resident requiring a plan of care has the potential to be affected by this deficiency 3) In-service education by the DON or designee on the proper timeframe of 7 days to complete comprehensive care plan 4) 100% Audit by the unit mgrs. Or designee of all residents on both units care plans to ensure compliance with timeframe completed along with audits to be completed for all new admissions on day 6 to ensure compliance and allow time for completion if non-compliant. Audit results reviewed in QAPI. 5) 11/18/19	

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dependence of two person physical assist in the area of transfer. This resident was assessed as requiring total dependence of one person physical assist in the area of locomotion, toilet and personal hygiene. This resident was assessed as always incontinent of bowel and bladder.

A Care Plan dated 09/15/19 included: Focus- Resident #23 has altered behavior due to refusal to get OOB (out of bed) on a daily basis, refuses showers, activities, and interaction with others. Refuses efforts to elevate heels when in bed. Goal- Will have fewer episodes of refusing out of bed. Interventions- Call family for assist when refusing out of the bed. Encourage diversional activities. Re-direct as needed.
Resident has history of attention seeking behavior of excessively ringing call bell. Goal- Resident's emotional and physical needs will be addressed when she rings the call bell excessively. Interventions- When resident rings the call bell excessively after needs have all been addressed determine if she is lonely or feeling badly by verbally asking her and request that Psych, NP or social worker speak with her to address her concerns of loneliness and anxiety if applicable to situation.

An Abuse Allegation conducted by the Administrator dated 03/19/19 Indicated: "(Resident #23) had been giving advice to all the younger staff for as long as she can remember and that a former CNA had been one of the younger staff she had recently mentored. Resident stated, that the former CNA had been coming to her as somewhat of a matchmaker and had been attempting to arrange sexual encounters with other staff members through her. The resident stated that this had been going on

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for a year now and provided names of a few staff members which she had said she did attempt to inform of the CNA's intentions.
Resident #23 also stated that the CNA washed her very well and took good care of her. The resident stated that she had asked him to clean an "itch" up inside her during perineal care and on occasion had requested that he go further inside while cleaning. She stated that she probably shouldn't have asked."

A Nursing Progress note dated 05/16/19 at 07:15 (7:15 a.m.) included: "This nurse was at resident's door at nurse cart and resident made an inappropriate request to this nurse. Resident stated "Can you take your finger and put it up my butt and move it around some." This nurse made resident aware the statement was inappropriate and this nurse could not. Resident made aware that social worker, unit manger, and Director of Nursing (DON) would be made aware to statement."

During an interview on 10/04/19 with the Administrator and Director of Nursing (DON), they were asked if Resident #23's care plan had been revised to include making inappropriate sexual comments to staff. The Administrator and the DON concurred that Resident #23's care plan had not been revised to include making inappropriate sexual comments.

2. For Resident #68, the facility staff failed to include the use of tube socks to bilateral arms to prevent scratching of a wound.

Resident #68 was re-admitted to the facility on 09/13/19 with diagnoses that included, but not limited to, dementia, Type 2 Diabetes mellitus

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without complications, dementia, depression, sepsis, osteomyelitis of vertebra, sacral and sacrococcygeal region.

A Quarterly Minimum Data Set (MDS) dated 09/04/19 assessed Resident #68 Brief Interview for Mental Status (BIMS) a score of 6 which indicated severe cognitive impairment. In the area of Functional Status this resident was assessed in the area of Activities of Daily Living (ADL'S) as requiring total dependence of two persons for bed mobility and toileting. Extensive assistance of one person physical assist for dressing and personal hygiene. In the area of Bladder and Bowel this resident was assessed as requiring an Indwelling Catheter.

A Care Plan dated 09/16/19 indicated: Focus- Resident #68 is at risk for impaired skin integrity R/T impaired mobility, bed/chair confined, F/C (Foley catheter) use, bowel incontinence, psychotropic med use, Underlying Disease, dementia, depression, DM, PVD, COPD, H/O, CVA with left side weakness. Goal- residents skin will be free of further breakdown through next review. Resident re-admitted with open wounds to sacrum, right hip, right medical shin, and left hip. Open wounds on 09/24/19 to right lateral 3rd toe (healed 10/1/19) and right medial 4th toe. Resident noted with wound vac due to multiple areas of skin impairment with deterioration.

On 10/01/19 at 12:45 PM Resident #68 was observed in bed with a pair of tube socks on both hands extending up his arms. This resident was observed again on 10/01/19 at 2:30 PM in bed with a pair of tube socks on both hands extending up his arms. The resident was observed on 10/02/19 at 8:53 AM in bed with a pair of tube

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F 657	Continued From page 28 socks on both hands extending up his arms. A review of the clinical records did not include a physician's order for the use of tube socks, nor did Resident #68's care plan include measures for the use of tube socks to reduce the resident's scratching. During an interview on 10/03/19 at 3:20 P.M. with LPN #6 (Licence Practical Nurse) she stated, "Resident #68 scratches the wound on his wound vac and some times pulls the wound vac out." During an interview on 10/04/19 at 11:15 A.M. with the Director of Nursing (DON) he was asked if Resident #68 had a physician's order for the use of the tube socks. The DON stated, Resident #68 did not have a physician's order for the use of tube socks. There was no restraint assessments for the use of the socks, no interventions for the treatment of itching or scratching behaviors and no alternate methods attempted prior to the use of the tube socks.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interviews, and clinical record review the facility staff failed to ensure 1 of 39 residents (Resident #21), in the survey sample received fingernail care prior to his fingernails becoming long with broken edges and a brownish substance beneath them.	F 677	1) CNA #1 was educated immediately on ADL assistance for dependent residents. The resident was provided fingernail care by CNA #1 immediately when notified. Physician was notified and saw patient same day for eval and treat. 2) All residents who are dependent on	11/18/19

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F 677	Continued From page 29 The findings included: Resident #21 was originally admitted to the facility 1/16/16 and had never been discharged from the facility. The current diagnoses included rheumatoid arthritis and severe deformity of bilateral feet. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 7/16/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #21's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of 1 person with eating, total care of two people with bed mobility and toileting and total care of one person with transfers, locomotion, dressing, personal hygiene and bathing. On 10/1/19 at approximately 11:45 a.m., Resident #21 was interviewed in his room. The resident was seated at the bedside and his fingernails were observed to be long; approximately 1.5 inches beyond the finger tips with a brown debris beneath them. Most of he resident's fingernails also had jagged and sharp edges. Resident #21 stated it had been a while since his fingernails had been cut and he would like to have them cut and filed evenly. Again on 10/2/19, at approximately 11:00 a.m., the resident's fingernails remained un-manicured as the day before. An interview was conducted with Certified	F 677	staff to provide necessary assistance with activities of daily living have the potential to be affected by this 3) In-service education by the DON or designee for nursing staff and new hires on Dependent residents nail and ADL care 4) Random Weekly audits by the unit mgrs or designee X90 days to check residents hygiene and grooming who are dependent on assistance 5) 11/18/19	

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F 677	Continued From page 30 Nursing Assistant (CNA) #1 on 10/3/19, at approximately 11:15 a.m. CNA #1 stated she would cut the resident's fingernails, clean then and ensure the uneven edges were smooth and she did. She also stated it was their responsibility to cut and clean fingernails as needed if they were not to thick. An interview was conducted with with Licensed Practical Nurse (LPN) #1 on 10/3/19, at approximately 2:45 p.m.. LPN #1 stated the CNA makes observations of fingernails and cut and keep them clean but if there is a diagnosis such as diabetes or use of certain medications the licensed nurse staff provides fingernail care. On 10/3/19, at approximately 6:00 p.m., the above findings were shared with the Director of Nursing and the Corporate Consultant. The Director of Nursing stated fingernail care is provided by the direct care staff (CNAs and licensed nurses if indicated).	F 677		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced	F 687		11/18/19

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F 687	Continued From page 31 by: Based on observation, resident interview, and staff interviews the facility staff failed to ensure 1 of 39 residents (Resident #21), in the survey sample received foot care prior to the toe nails advancing to painful, long and curvy nails. The findings included: Resident #21 was originally admitted to the facility 1/16/16, and had never been discharged from the facility. The current diagnoses included; rheumatoid arthritis and severe deformity of bilateral feet. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 7/16/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #21's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of 1 person with eating, total care of two people with bed mobility and toileting and total care of one person with transfers, locomotion, dressing, personal hygiene and bathing. On 10/1/19 at approximately 11:45 a.m., Resident #21 was interviewed in his room. The resident was seated at the bedside and he complained of his toe nail being long and painful. The resident was wearing socks therefore his toe nails could not be observed at that time. Resident #21 stated it had been a long time since his toe nails had been cut and filed and now they hurt constantly. Again on 10/2/19, at approximately 11:00 a.m., the resident complained that his toe nails were	F 687	1) LPN #1 educated immediately on skin checks. LPN #1 assessed resident's feet and requested physician to assess. Physician evaluated and ordered treatment including managing pain and order for Podiatrist appointment. Resident has seen podiatrist with ongoing follow up to occur. 2) All residents who are dependent on staff to provide necessary assistance with activities of daily living have the potential to be affected by this 3) In-service education by the DON or designee for nursing staff and new hires on Dependent residents on professional standards of foot care 4) Random Weekly audits by the unit mgrs or designee X90 days to check hygiene and grooming along with routine podiatry consults to be provided by facility. Audit results to be reviewed in QAPI. 5) 11/18/19	

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hurting.

On 10/2/19 at approximately 2:50 p.m., the Unit Manager was notified that the resident complained of his toe nail hurting and that he would like to have his toe nails cut. The Unit Manager stated the resident resided in the facility under a Veteran's contract so their podiatrist would not be able to see him.

On 10/3/19 at approximately 11:15 a.m., Certified Nursing Assistant (CNA) #1 was observed providing care to Resident #21. CNA #1 removed the resident's socks and large flakes of dried skin fell from his feet, also very large bunions were observed bilaterally and the great toes overlapped the 2nd toe, and each toe overlapped the other. All toe nails were extremely thick, brownish and long and curvy with the appearance like a ram's horn.

An interview was conducted with with CNA #1 on 10/3/19, at approximately 11:15 a.m., she stated CNAs don't cut the resident's toenails. CNA #1 also stated if the resident complained of painful toe nails or if she felt toenails needed attention for cutting she would notify the charge nurse. Licensed Practical Nurse #1 was asked to make an observation of the Resident #21's toe nails.

An interview was conducted with on 10/3/19, at approximately 2:45 p.m., with Licensed Practical Nurse (LPN) #1. LPN stated the CNAs makes observations of toe nails during care and notifies the licensed nurses if they need to see the podiatrist. LPN #1 also stated during skin assessments she would assess the resident's feet but only for skin tears or open areas. LPN #1 further stated she asked the physician who was in

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F 687	Continued From page 33 the facility at the time to assess the resident's feet; the physician ordered Aquaphor to be applied to bilateral feet daily, gauze between the toes as needed and podiatry services and Tylenol was administered for the resident's complaint of painful toe nails. On 10/3/19, at approximately 6:00 p.m., the above findings were shared with the Director of Nursing and the Corporate Consultant. The Director of Nursing stated whatever services a resident needs is provided and/or coordinated by the facility's staff. The Director of Nursing stated he should have received podiatry services before his nails reached the described state.	F 687		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to practice safe bed mobility for one of 39 residents in the survey sample, Resident #26, resulting in an avoidable fall with a head laceration, that lead to an acute transfer to the hospital which constitutes harm. The findings include:	F 689	Past noncompliance: no plan of correction required.	10/29/19

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Resident #26 was admitted to the facility on 6/4/12 with diagnoses that included but were not limited to dementia without behavioral disturbance, high cholesterol, type two diabetes and adult failure to thrive. Resident #26's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 7/16/19. Resident #26 was coded as being severely impaired in cognitive function scoring 04 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Section G (functional status) coded Resident #26 as requiring extensive assistance from one staff member for bed mobility.

Review of Resident #26's clinical record revealed that she was had a fall on 9/3/19 and was transferred to the hospital. The following note was written: "The CNA (certified nursing assistant) stated that she was changing her brief. The CNA stated that when she turned her, the resident fell out of bed, hitting her head on the corner of the night stand. Immediate intervention: The resident was sent out to the emergency room for evaluation. Vitals: BP (blood pressure): 139/81, Position: Lying l (left) arm. P (pulse) 81 Pulse Type: regular. Resident cooperative. Resident has full range of motion to all extremities. Neurological checks are within normal limits. Evidence of pain noted. Pain to her head. Pain is throbbing Pain level is 6 out of 10. The pain is constant Pain persistent daily. Pain medication...This writer was called down to the residents room by the CNA, the resident was observed laying on her right side side between the bed and night stand, the resident was observed bleeding from a laceration to the front of her head. 911 was called and the paramedics were here minutes later to (sic) without difficulty.

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The resident is complaining of pain to her head. 911 was called and paramedics were here minutes later to transport the resident to the ER (emergency room)...report was given to the ER nurse."

Review of the fall incident report dated 9/3/19 documented the following : "Incident Description: The resident was observed laying on the floor in her right side, bleeding from a laceration to the front of her head. Resident was assessed and sent to the hospital." There was no additional information documented on the incident report.

Review of Resident #26's ADL (activities of daily living) care plan initiated on 5/12/16, documented Resident #26 as requiring Bathing/Hygiene assist of: 1 (one person)." Resident #26 was also documented as requiring an "assist of 2 with turning and repositioning/bed mobility with assist of 2."

Review of Resident #26's current nursing Kardex (Resident care guide for nursing aides) documented Resident #26 as requiring one person physical assist with bed mobility.

Review of Resident #26's clinical record revealed the most recent fall risk assessment prior to her fall on 9/3/19 was conducted on 4/15/16. Resident #26 was coded at a level "10.0" indicating she was at high risk for falls.

Further review of Resident #26's clinical record revealed that Resident #26 arrived the same day (9/3/19) with a laceration to her forehead. The following was documented: "9/3/19 at 19:23 (7:23 p.m.) Resident returned from the hospital @ (at) 1640 (4:40 p.m.). Stitches noted to right forehead

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covered with dry drsg (dressing). No drainage noted. Resident has no c/o (complaints) of pain. No s/s (signs and symptoms) of acute resp (respiratory) or cardiac distress noted."

Review of Resident #26's weekly wound assessment dated 9/4/19 documented the following: "Wound Type: Laceration...Wound Location: Forehead. Length (cm) (centimeters): 3.5 Width (cm): 0.1...Presents with 100% granulation tissue and 5 intact sutures. Edges well approximated. No s/s (signs/symptoms) of infection or dehiscence."

Review of an IDT (interdisciplinary note) dated 9/6/19 documented the following: "Par (sic) meeting hed today. All I.D.T. present. Resident noted to have s (sic) laceration to forehead with 5 sutures. Resident is table (sic). No ne (sic) intervetions at this time."

Further review of Resident #26's clinical record revealed her laceration had healed on 9/17/19.

Review of Resident #26's assessments revealed that Q (every)15 (minute), Q30, Q1 (hour), Q4 hr and Q8 hr neurological checks were conducted until 9/6/19.

Further review of Resident #26's assessments revealed an updated Fall Risk assessment conducted 9/3/19. This assessment documented Resident #26 as being at high risk for falls, scoring a level "16.0."

On 10/3/19 at 9:14 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #1, the nurse who was assigned to Resident #26 at the time of her fall. When asked how many

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people it required to provided incontinence care to Resident #26, LPN #1 stated it only took one person. When asked what she could recall about Resident #26's fall on 9/3/19, LPN #1 stated that she was called down to the room by the CNA and found Resident #26 on the right side of the bed, laying on her right side. LPN #1 stated that the resident had fallen while the nursing aide was turning her during incontinence care. LPN #1 stated that Resident #26 was sent out to the hospital for a laceration to her head. LPN #1 stated that the nursing aide was a new employee at the time but she wasn't certain of her name. LPN #1 was asked to get this nursing aide's contact information.

On 10/3/19 at 9:31 a.m., an interview was conducted with LPN #7, the MDS nurse. When asked who was responsible for developing care plans, LPN #7 stated that she was responsible. When asked how many assist Resident #26 was with incontinence care, LPN #7 stated that Resident #26 was extensive assistance with one staff member. When asked why Resident #26's care plan documented an assist of one with bathing/hygiene but assist of two with turning and repositioning and bed mobility, LPN #7 stated that Resident #26 was an assist with one for turning but that it required to staff members to lift her up in bed (slide back up).

On 10/3/19 at 12:04 p.m., incontinence care was observed for Resident #26 with CNA #4, her assigned nursing assistant that shift. There were no concerns related to bed mobility and turning and respositioning.

On 10/3/19 at 1:12 p.m., an interview was conducted with CNA #3, the aide who was

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present during Resident #26's fall on 9/3/19. When asked how she provides incontinence care to a resident who is extensive assistance, CNA #3 stated that when she is providing incontinence care for a resident who is extensive assistance, she will first undo the brief, turn the resident toward her (with her standing in front of the resident), pull the brief out, wash the resident, tuck a new brief underneath, place the resident back on their back and then she will walk around the bed, turn the resident to the other side of the bed (with the aide in front of her), and then she will secure the brief. When asked how many assist Resident #26 was with incontinence care, CNA #3 stated that she extensive assist with one staff member. When asked what she could recall on 9/3/19 with Resident #26's fall, CNA #3 stated that she didn't pull Resident #26 to the center of the bed prior to turning her on her side. CNA #3 stated that she didn't realize how close Resident #26 was to the edge of the bed prior to turning her. CNA #3 stated that she tried to stop the fall but that Resident #26 was too heavy and fell off the bed. CNA #3 stated that Resident #26's head went down and hit the nightstand. When asked if any education was provided to her after this incident, CNA #3 stated that administration did an in-service with her and other staff about proper turning and respositioning.

On 10/3/19 at 2:42 p.m., a concern for harm was addressed with ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), ASM #3, the Regional Director of Clinical Services, and RN (registered nurse) #1, the ADON (assistant director of nursing). Education that was provided to staff after the incident on 9/3/19 was requested.

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F 689	Continued From page 39 On 10/3/19 at approximately 4 p.m., signature sheets dated 9/4/19 were presented. CNA #3's signature was on this sheet as well as 16 other nursing assistants. The following was documented on the signature sheet: "Subject: Repositioning residents while in bed. Participants: Nursing Staff." The content of this education was requested from RN #1. On 10/4/19 at approximately 10:00 a.m., RN #1 presented the content of the education provided on 9/4/19. The following was documented: "9/4/19 Proper positioning of resident while in bed...1. Before providing care be sure to have the appropriate amount of staff assisting, (i.e. 1 or 2 person assist, per plan of care). 2. When assisting a resident up in bed, lower the head of the bed, elevate the feet and have the resident use their legs to push up. Lowering the head of the bed and elevating the feet, will allow gravity to help. 3. When turning a resident from side to side, be sure that the resident is toward the center of the bed and using the draw sheet roll the resident on their side. Pillows or wedges can be used to maintain resident in side position. 4. Please remember that it is ok to ask for help if needed." On 10/4/19 at 11:45 a.m., review of the facility's incident and accident log revealed no falls with major injuries since 9/3/19. On 10/3/19 at approximately 10:45 a.m., ASM #2, the DON and ASM #3, the Regional Director of Clinical Services were made aware that this concern would be past non-compliance.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		11/18/19

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F 695	Continued From page 40 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, family interview, staff interview, and clinical record review, the facility staff failed to ensure necessary respiratory care and services were provided for 2 of 39 residents in the survey sample (Residents #97 and #10). For Resident #97, the facility staff failed to ensure resident specific tracheostomy equipment was easily accessible in case of an emergency, failed to provide tracheostomy care without compromising the resident's respiration/airway and failed to administer oxygen (O2) as ordered. For Resident #10, the facility staff failed to administer oxygen as ordered. The findings included: 1. Resident #97 was originally admitted to the facility 9/6/19 and had never been discharged from the facility. The current diagnoses included sarcoidosis requiring a tracheostomy. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/13/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 0 out of a possible 15. This indicated Resident #97's cognitive abilities for	F 695	1) A. LPN #1 Immediately educated on Trach care and given competency which she completed same day. All nurses reported to mandatory Trach Care In-service provided by Respiratory Therapist of sister building on 10/11/19. B. LPN #9 and #10 were educated on checking charts at beginning of shift and thorough shift change reports to ensure continuity of care. New Signs were made stating “the oxygen level on this machine should be at _____lpm.” Signs were placed on all concentrators. 2) All residents that require trach care and or oxygen services have the potential to be affected by this deficiency 3.) A. In service education on trach care along with competency from the DON or designee. Annual trach care in- services and competency for all nursing dept. B. Education on oxygen orders by the DON or designee to be performed 4.) Random Weekly audits by the unit mgrs or designee X 90days to check Oxygen levels on concentrators and report discrepancies to physician and	

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F 695	Continued From page 41 daily decision making were severely impaired. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of 1 person with bed mobility and total care with locomotion, dressing, eating, toileting, personal hygiene and bathing. Observations were made of the resident's room on 10/2/19, at approximately 11:00 a.m., with Licensed Practical Nurse (LPN) #1. An ambu bag was on the table near the foot of the bed, gauzes, an inner cannula and a trach system with an inner cannula was in the top drawer of the table near the foot of the bed. The Unit Manager stated the items in the top drawer were not the current trach equipment the resident required for the trach system the resident was currently utilizing; it didn't include an inner cannula. Further observation of the resident's room revealed a suction machine which was operational and a Yankauer oral suction tube was present however no trach catheters, sterile water or saline were in the room. A compressed oxygen machine was on the bedside table with the suction machine but and it was not delivering oxygen at 3 liter per minutes via trach collar as ordered on 9/9/19. There was no trach collar and the O2 machine wasn't on. On 10/2/19 at 1:30 p.m., a bag with the correct tracheostomy tube and other tracheostomy supplies was observed attached to the cork board in the resident's room. An observation of LPN #1 providing trach care to Resident #97 was made; the resident was observed lying on his left side and sliding down in the bed. The tube feeding was running at 60 milliliter per hour. The resident had a large amount of secretions pooling on the right side of his neck and the trach ties appeared saturated. LPN #1 opened the supplies and	F 695	DON for correction daily with long term results to be shared at QAPI 5) 11/18/19	

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placed them on an over the bed table, she opened a cotton tip applicator and swabbed around the trach opening, then she opened the gauze packets and poured saline on the gauze, wiped and the resident's neck four times until all the pooling secretions were removed from his skin. LPN #1 then removed the left side trach tie, then the right trach tie, leaving the resident's trach unsecured, not even holding it in place with her hands. LPN #1 turned to the table and began removing the new trach ties from the container and the surveyors stated "I am concerned because if the resident coughs the tracheostomy tube will be dislodged and the resident will lose his ability to breath." LPN #1 continued to prepare her supplies leaving the tracheostomy tube unsecured and the resident coughed, the tube was expelled and the resident began to gasp for breath and show body restlessness. The surveyor notified staff at the nursing station there was an emergency in the resident's room and LPN #1 retrieved the tracheostomy tube and reinserted it into the resident's trachea, applied the new trach ties and clean gauze around the tracheostomy tube, obtain a pulse oximeter reading of 92%, cleaned up the unused supplies and left the resident's room. The oxygen via trach collar still wasn't provided.

On 10/2/19 at approximately 6:15 p.m., Resident #97's wife was observed seated at his bedside. She stated it was difficult seeing her husband in his current state for most of his life he was the life of a party. He always made everyone laugh and he enjoyed seeing others happy. The wife then stated her husband had sarcoidosis which progressed and required use of the tracheostomy. She added she took care of her husband at home so suctioning him wasn't a

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concern for her but the facility's nurses had told her they couldn't perform deep suctioning too often remove secretions. She further stated the staff does a good job keeping her husband clean but they were not doing a good job keeping his abdominal binder on and with his trach care. She stated when she entered his room earlier she had to suction him because he had a large amount of secretions pooling around his neck and there was a rattle in his trach. She also stated the facility's staff don't keep suctioning catheters in the room like she would like for them to therefore she had to ask for one and sterile water to suction him. Resident #97's wife then stated she would like for the staff to suction him before she left because he wasn't rattling again. The wife stated the resident had a large amount of scar tissue in his trachea area because he had dislodged his inner cannula and or trach tube multiple times and his current tracheostomy tube was his fourth placement.

Review of Resident #97's physician orders revealed the following orders: 9/9/19, oxygen at 3 liter per minute via trach, FIO2 28% via trach collar every shift. Suction assessment every 4 hours as needed for suctioning. Trach assessment daily every shift for trach. Trach assessment daily every shift for trach. Trach ties/collar to be changed on bath days/PRN as needed.

On 10/3/19 at approximately 3:00 p.m.,an interview was conducted with LPN #1 accompanied by the Assistant Director of Nursing. LPN #1 acknowledged she should have positioned the resident on his back and extended his neck as well as she probably should have stopped the tube feeding prior to beginning trach

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care. LPN #1 also answered yes when asked if she should have assessed the resident's respiratory status for: ease of breathing, respiratory rate, pulse rate, amount of secretions and appearance, and for the presence of secretions on the residents neck or trach ties. LPN #1 stated "Now I understand why you stated you were concerned when the trach ties were removed but it wasn't the first time his airway had been compromised by dislodgement of the tracheostomy tube." LPN #1 stated she didn't feel the resident required suctioning but she didn't state what led her to that conclusion. LPN #1 also expressed she felt the surveyor should have offered her guidance in providing tracheostomy care.

On 10/3/19, at approximately 6:00 p.m., the above findings were shared with the Director of Nursing and the Corporate Consultant. The Director of Nursing stated the a local respiratory company had in-serviced staff on tracheostomy care. The document they provided on 10/4/19, stated the facility's staff received training 2/15/18, but a sign-in document revealing the actual participants was provided. The Director of Nursing and the Corporate Consultant were unable to state what LPN #1 should have done to fulfill the suction assessment and no information was provided to clarify what the order suction assessment meant. The Corporate Consultant stated arrangements had been made for a Respiratory Therapist to come in later in the week.

2. Resident #10 was admitted to the facility on 10/27/17 and readmitted on 9/11/19 with diagnoses that included but were not limited to epilepsy, type two diabetes, high blood pressure,

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heart failure, hemiplegia (one sided paralysis) following stroke and major depressive disorder. Resident #10's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 7/2/19. Resident #10 was coded with moderate cognitive impairment scoring 12 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

On 10/2/19 at 12:00 p.m., an observation was made of Resident #10. She was lying in bed with oxygen on via nasal cannula. Her oxygen flow meter was set to 4 liters of oxygen. When asked how she was breathing, Resident #10 stated she was breathing fine.

On 10/2/19 at 5:15 p.m., a second observation was made of Resident #10. She was lying in bed with oxygen on via nasal cannula. Her oxygen flow meter was set to 4 liters of oxygen.

Review of Resident #10's October 2019 POS (physician order sheet) revealed the following oxygen order initiated on 9/12/19: "Oxygen at (2) LPM (liters per minute) via nasal cannula every shift for SOB (shortness of breath)."

Review of Resident #10's oxygen care plan dated 9/30/19, documented the following: "(Name of Resident #10) requires oxygen R/T (related to) CHF (congestive heart failure), SOB. Goal: Residents oxygen levels will be kept as desired levels per MD (medical doctor) orders through next review. Interventions: Administer oxygen as ordered."

Review of Resident #10's clinical record revealed that Resident #10 had been sent to the hospital on 10/1/19 for abnormal laboratory tests and

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elevated blood pressure. Resident #10 was admitted back to the facility on 10/2/19 at 4:00 a.m. There was no evidence that her oxygen was ordered to be increased to 4 liters after this hospitalization.

On 10/2/19 at 5:25 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #9, Resident #10's nurse. When asked how many liters of oxygen Resident #10 was supposed to be on, LPN #9 stated, "I think it is two, I have to check." LPN #9 checked Resident #10's current physician orders and stated that her order was for two liters. When asked if she had already seen Resident #10 that shift, LPN #9 stated that she was her nurse 7-3 and 3-11 shift and had just seen Resident #10 about an hour and a half ago. When asked if she had checked Resident #10's oxygen flow meter that day, LPN #9 stated that she had not yet checked her flow meter. LPN #9 did not mention Resident #10 having any respiratory distress that shift. This writer then followed LPN #9 to Resident #10's room. LPN #9 checked Resident #10's oxygen and stated that her oxygen flow meter was set to 4 liters and that it should be set to two liters. When asked if Resident #10 was able to adjust her own oxygen, LPN #9 stated that Resident #10 could not. When asked if there could be any adverse effects from receiving too much oxygen, LPN #2 stated that receiving too much oxygen could harm her lungs. LPN #9 could not explain why receiving too much oxygen could harm her lungs.

On 10/3/19 at 6:05 p.m., an interview was conducted with ASM #2, the Director of Nursing. ASM #2 stated that on 10/1/19 Resident #10 was having respiratory distress and that he received an order from the Nurse Practitioner to increase

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F 695	Continued From page 47 Resident #10's oxygen up to 4 liters prn (as needed). ASM #2 stated that he had just put the new order in as a late entry on 10/3/19. ASM #2 and this writer looked at Resident #10's chart for 10/2/19. This writer showed ASM #2 that there was no evidence she was having respiratory distress on 10/2/19. ASM #2 stated that the nurse practitioner wanted Resident #10 to stay on 2 liters continuous and move up to 4 liters if needed. When asked how he would know to increase Resident #10's oxygen if it remained on 4 liters on 10/2/19, ASM #2 stated that he was not sure what happened since this writer's observation was only from 12 p.m. to 5:15 p.m. This writer explained to ASM #2 that LPN #9 (the 7-3 and 3-11 shift nurse for Resident #10 on 10/2/19) did not mention anything related to Resident #10 having respiratory distress on 10/2/19 prior to this writer's observation. This writer explained that LPN #9 had stated that she did not check Resident #10's flow meter yet that day. On 10/4/19 at 10:46 a.m., during the pre-exit meeting, ASM (administrative staff member) #1, the Administrator, ASM #2, the Director of Nursing and ASM #3, the Regional Director of Clinical Services were made aware of the above concerns. A policy could not be provided regarding the above concerns. No further information was presented prior to exit.	F 695		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure	F 726		11/18/19

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F 726	Continued From page 48 resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, family interview and staff interviews the facility staff failed to ensure staff was competent in tracheostomy tube care for 1 of 39 residents (Resident #97), in the survey sample. The findings included: Resident #97 was originally admitted to the facility 9/6/19 and had never been discharged from the facility. The current diagnoses included	F 726	1) LPN #1 immediately educated on the proper supplies involved with trach care, what the suction assessment entails and the importance of ensuring proper backup supplies at bedside. Competency test also given with passing results that day. 2) All residents that require trach care have the potential to be affected by this deficiency 3) In service education on trach care along with competency from the DON or	

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F 726	Continued From page 49 sarcoidosis requiring a tracheostomy. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/13/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 0 out of a possible 15. This indicated Resident #97's cognitive abilities for daily decision making were severely impaired. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of 1 person with bed mobility and total care with locomotion, dressing, eating, toileting, personal hygiene and bathing. Observations were made of the resident's room on 10/2/19, at approximately 11:00 a.m., with Licensed Practical Nurse #1. An ambu bag was on the table near the foot of the bed, gauzes, an inner cannula and a trach system with an inner cannula was in the top drawer of the table near the foot of the bed. The Unit Manager stated the items in the top drawer were not the current trach equipment the resident required for the trach system the resident was currently utilizing didn't include an inner cannula. Further observation of the resident's room revealed a suction machine which was operational and a Yankauer oral suction tube was present but; no trach catheters, sterile water or saline were in the room. A compressed oxygen machine was on the bedside table with the suction machine but and it was not delivering oxygen at 3 liter per minutes via trach collar as ordered on 9/9/19. There was no trach collar and the O2 machine wasn't on. On 10/2/19 at 1:30 p.m., a bag with the correct tracheostomy tube and other tracheostomy supplies was observed attached to the cork board	F 726	designee. Annual trach care in- services and competency for all nursing dept All nurses reported to mandatory Trach Care In-service provided by Respiratory Therapist of sister building on 10/11/19. 4) Annual Trach care competencies and weekly audits of trach care to be performed with DON or designee present including inventory of bed side trach supplies X90 days. 5) 11/18/19	

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in the resident's room. An observation of Licensed Practical Nurse (LPN) #1 providing trach care to Resident #97 was made; the resident was observed lying on his left side and sliding down in the bed. The tube feeding was running at 60 milliliter per hour. The resident had a large amount of secretions pooling on the right side of his neck and the trach ties appeared saturated. LPN #1 opened the supplies and placed them on an over the bed table, she opened a cotton tip applicator and swabbed around the trach opening, then she opened the gauze packets and poured saline on the gauze, wiped and the resident's neck four times until all the pooling secretions were removed from his skin. LPN #1 then removed the left side trach tie, then the right trach tie, leaving the resident's trach unsecured, not even holding it in place with her hands. LPN #1 turned to the table and began removing the new trach ties from the container and the surveyors stated "I am concerned because if the resident coughs the tracheostomy tube will be dislodged and the resident will lose his ability to breath." LPN #1 continued to prepare her supplies leaving the tracheostomy tube unsecured and the resident coughed, the tube was expelled and the resident began to gasp for breath and show body restlessness. The surveyor notified staff at the nursing station there was an emergency in the resident's room and LPN #1 retrieved the tracheostomy tube and reinserted it into the resident's trachea, applied the new trach ties and clean gauze around the tracheostomy tube, obtain a pulse oximeter reading of 92%, cleaned up the unused supplies and left the resident's room. The oxygen via trach collar still wasn't provided.

On 10/2/19 at approximately 6:15 p.m., Resident

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#97's wife was observed seated at his bedside. She stated it was difficult seeing her husband in his current state for most of his life he was the life of a party. He always made everyone laugh and he enjoyed seeing others happy. The wife then stated her husband had sarcoidosis which progressed and required use of the tracheostomy. She added she took care of her husband at home so suctioning him wasn't a concern for her but the facility's nurses had told her they couldn't perform deep suctioning when to often remove secretions. She further stated the staff does a good job keeping her husband clean but they were not doing a good job keeping his abdominal binder on and with his trach care. She stated when she entered his room earlier she had to suction him because he had a large amount of secretions pooling around his neck and there was a rattle in his trach. She also stated the facility's staff don't keep suctioning catheters in the room like she would like for them to therefore she had to ask for one and sterile water to suction him. Resident #97's wife then stated she would like for the staff to suction him before she left because he wasn't rattling again. The wife stated the resident had a large amount of scar tissue in her trachea area because he had dislodged his inner cannula and or trach tube multiple times and his current tracheostomy tube was his fourth placement.

Review of Resident #97's physician orders revealed the following orders: 9/9/19, oxygen at 3 liter per minute via trach, FIO2 28% via trach collar every shift. Suction assessment every 4 hours as needed for suctioning. Trach assessment daily every shift for trach. Trach assessment daily every shift for trach. Trach ties/collar to be changed on bath days/PRN as

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needed.

On 10/3/19 at approximately 3:00 p.m.,an interview was conducted with LPN #1 accompanied by the Assistant Director of Nursing. LPN #1 acknowledged she should have positioned the resident on his back and extended his neck as well as she probably should have stopped the tube feeding prior to beginning trach care. LPN #1 also answered, yes, when asked if she should have assessed the resident's respiratory status for; ease of breathing, respiratory rate, pulse rate, amount of secretions and appearance, and for the presence of secretions on the residents neck or trach ties. LPN #1 stated "now I understand why you stated you were concerned when the trach ties were removed but it wasn't the first time his airway had been compromised by dislodgement of the tracheostomy tube." LPN #1 stated she didn't feel the resident required suctioning but she didn't state what lead her to that conclusion. LPN #1 also expressed she felt the surveyor should have offered her guidance in providing tracheostomy care.

On 10/3/19, at approximately 6:00 p.m., the above findings were shared with the Director of Nursing and the Corporate Consultant. The Director of Nursing stated the a local respiratory company had in-serviced staff on tracheostomy care. The document they provided on 10/4/19, stated the facility's staff received training 2/15/18, but a sign-in document revealing the actual participants was not provided. The Director of Nursing and the Corporate Consultant were unable to state what LPN #1 should have done to fulfill the suction assessment and no information was provided to clarify what the order suction

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F 726	Continued From page 53 assessment meant. The Corporate Consultant stated arrangements had been made for a Respiratory Therapist to come in later in the week.	F 726		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to ensure there was Registered Nurse (RN) coverage for eight consecutive hours in a twenty-four hour period. The findings include: During review of the facility's staffing for Registered Nurse coverage, the facility failed to ensure there was an RN for at least 8 consecutive hours a day seven days a week on 12/1/18, 12/2/18, 12/16/18, and 12/22/18. On 10/4/19 at 9:49 a.m., an interview was	F 727	1. No residents where affected related to this deficient practice. Facility is currently sufficient with RN coverage. 2. All residents at risk. 3. Nursing schedule reviewed daily at Morning Department Head meeting by Administrator or Designee to ensure 8hrs of consecutive RN coverage for that day and any calendar days that occur immediately after that day until the next business day. 4. Daily audit x3 months of Time Tracks RN Time Card Report and results reviewed in QAPI. 5. 11/18/19	11/18/19

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F 727	Continued From page 54 conducted with the scheduler Other staff member (OSM) #4. When asked how long she had been creating the schedule, OSM #4 stated that she had been doing the schedule for four years. When asked if it was difficult to get RN coverage back in December of 2018, OSM #4 stated, "On the weekends. Yes." OSM #4 stated that there should be an RN on shift for 8 hours in a 24 hour period. OSM #4 confirmed through review of the as worked nursing staffing schedule that there was no RN coverage 8 consecutive hours in the 24 hours on 12/1/18, 12/2/18, 12/16/18, and 12/22/18. On 10/4/19 at 10:46 a.m., during the pre-exit meeting, ASM (administrative staff member) #1, the Administrator, ASM #2, the Director of Nursing and ASM #3, the Regional Director of Clinical Services were made aware of the above concerns. No further information was provided by the facility staff.	F 727		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755		11/18/19

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F 755	Continued From page 55 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based record review and staff interview the facility staff failed to ensure medications were available for administration for two residents (Resident #68 and Resident #96) in the survey sample of 39 residents. The findings included: 1. Resident #68 was re-admitted to the facility on 09/13/19 with diagnoses which included, but not limited to, sepsis, osteomyelitis of vertebra, sacral and sacrococcygeal region, Type 2 Diabetes mellitus without complications, dementia, and chronic obstructive pulmonary disease (COPD). A Quarterly Minimum Data Set (MDS) dated 09/04/19 assessed this resident in the area of Hearing, Speech, and Vision as having unclear speech. In the area of Cognitive Patterns this	F 755	1) Resident #96 was evaluated on 10/3/19 by NP, was started on Omeprazole. Resident #96 no longer resides at facility. Resident #68 completed course of Vancomycin on 10/25/19 as ordered by physician. 2) Any resident requiring any medications here has the potential to be affected by this deficiency 3) In-service education by the DON or designee on PAR levels and inventory counts completed with Central Supply. In-service education of all licensed nurses on contents/use of IV stat tower. 4) Random audits of PAR sheets every week by DON or Designee to be completed X90 days. Random weekly audit of Licensed Nurses on contents/use of IV stat tower x90 days. Audit results reviewed in QAPI.	

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F 755	Continued From page 56 resident received a Brief Interview for Mental Status (BIMS) score of 6 which indicated severe cognitive impairment. In the area of Functional Status this resident was assessed in the area of Activities of Daily Living (ADL) as requiring total dependence of two persons for bed mobility and toileting. Extensive assistance of one person physical assist for dressing and personal hygiene. In the area of Bladder and Bowel this resident was assessed as requiring an Indwelling Catheter. In the area of Medications this resident was assessed as receiving antibiotics during the last 7 days of reentry. A Revised Care Plan dated 09/16/19 indicated: Resident #68 is on IV (intravenous) (ABT) antibiotic-Vancomycin IV X 35 days R/T sepsis. Goal- Resident infection will resolve without complications by Vancomycin. Interventions- Notify physician if course of treatment appears to be ineffective, medications as ordered. A Progress Note dated 09/22/19 at (14:28) 2:28 P.M. indicated: "Resident missed 18:00 dose of IV Vancomycin 1 gram on Saturday 09/21/19 due to pharmacy not delivering...sending to wrong facility. NP (Nurse Practitioner) contacted, new order to pull Vancomycin from stat tower and give now at 09:00 (9 AM) was received. LPN (Licensed Practical Nurse) used Vancomycin 1 gram from stat tower and reconstituted it and added to 250 ml of NS (normal saline) per pharmacy advice. New time for his Vancomycin is now at 09:00 AM. Pharmacy was made aware and stated that they will be sending his 09:00 AM dose of Vanco for 09/23/19 and to retake his Vanco trough 1/2 before his next dose." The nurse who did not administer the medication on 9/21/19 was not available for interview.	F 755	5) 11/18/19	

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During an interview on 10/04/19 at 10:00 A.M. with the Director of Nursing he stated the pharmacy did not have the medication available on 09/22/19.

2. Resident #96 was originally admitted to the facility 9/4/19 and has never been discharged from the facility. The current diagnoses included; gastritis (inflammation of the stomach lining).

The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/11/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 9 out of a possible 15. This indicated Resident #96's cognitive abilities for daily decision making were moderately impaired. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of one person with bed mobility, transfers, dressing, eating, toileting, personal hygiene and bathing, and total care with locomotion.

During the medication and pass and pour observation on 10/1/19, at approximately 5:53 p.m., Licensed Practical Nurse (LPN) #9 stated she didn't have Ranitidine 75 milligrams on the medication cart but she would retrieve some from the over the counter drug supply. Upon return to the medication cart she stated she had to telephone the physician for further orders because there was no Ranitidine 75 milligrams in the facility. At approximately 6:25 p.m., someone yelled down the hall to LPN #9 that the Ranitidine order had been discontinued because it was a recall medication.

Reviewed of Resident #96's physician orders

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revealed an order dated 10/1/19 at 6:21 p.m., to discontinue the order for Ranitidine 75 milligrams two times a day for gastritis.

An interview was conducted with the Nurse Practitioner (NP) on 10/2/19 at approximately 4:45 p.m. The NP stated the she didn't believe Resident #96 had gastritis but she had reflux disease therefore she was doing a trial discontinuation of the medication Ranitidine. The NP further stated the physician initially assessed the resident and she had not yet evaluated her but she would get back with me afterwards.

On 10/3/19 at approximately 11:20 a.m., an interview was conducted with the Supply clerk (she orders the over the counter medications) about not having Ranitidine 75 milligrams in stock. The supply clerk stated after reviewing her computer system there was no indication that she had never stocked the over the counter medication Ranitidine therefore it apparently had been obtained from some other supplier. She also stated the supplier the facility utilizes had the medication available to be ordered and if she had been notified she could have had it in the facility within one day.

On 10/3/19, the NP stated it was reported to her that Resident #96, had vomited but she wasn't certain if it was related to discontinuation of the medication Ranitidine or if it was just something the resident had consumed but she would assess the resident.

On 10/3/19 at approximately 6:00 p.m., the above findings were shared with the Director of Nursing and Corporate consultant. The Director of Nursing stated he was aware the medication

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F 755	Continued From page 59 Ranitidine 75 milligrams wasn't available for administration to resident #96 during the medication pass and pour and he had been planning to develop a par level for over the counter medication but he had not yet gotten around to it. The Corporate consultant stated the documentation of the NP reported episode of Resident #96 vomiting 10/2/19, was not in the clinical record.	F 755		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interviews, clinical record review, the facility's staff failed to review food preference with the resident and provide like food alternatives for 1 of 39 residents (Resident #95), in the survey sample. The findings included: Resident #95 was originally admitted to the facility 9/12/19 and the resident has never been discharged from the facility. The current diagnoses included; stroke with left hemiparesis.	F 806	1. Dietary Manager interviewed resident #95 for his preferences and discussed the diet that is recommended for him. 2. Facility population audited for any similar incidents by Dietary Manager or designee. 3. New admissions reviewed the following day at Morning Clinical Meeting to ensure dietary preference's interview completed and resident aware of his/her prescribed diet. 4. Weekly audit x3 months of new admissions for dietary preferences interview being completed and resident	11/18/19

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F 806	Continued From page 60 The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/18/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #95's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of 1 person with locomotion, dressing, eating, toileting, and personal hygiene, extensive assistance of 2 people with bathing, bed mobility, and transfers. On 10/1/19 at approximately 4:00 p.m., after the Resident Council meeting, Resident #95 stated "I'm a young man with a wife and children. I had a stroke and am here for rehabilitation therapy. I decided while I was hospitalized that I wanted to develop a healthy lifestyle including increased exercise and eating healthier foods, preferably salads for two meals daily." Resident #95 further stated "I have told the nurses almost daily that I don't want pork, gravies, or fried food or most of the foods they have been serving me, I want more vegetables and salads for lunch and dinner, but I'm still not receiving salads." The resident stated nothing has changed concerning the foods he dislikes therefore his family is bringing food in for lunch and dinner as well as leaving other food in his room for when he wants a snack. The resident stated no one had interviewed him for his food preferences or explained to him what type of diet was recommended or ordered for him and he had not met any person who identified themselves as dietary staff. The Dietary Manager was interviewed in her office, on 10/1/19, at approximately 4:10 p.m., she stated she hadn't reviewed food preferences	F 806	aware of his/her prescribed diet. Results reviewed in QAPI. 5. 11/18/19	

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F 806	Continued From page 61 with Resident #95 but she had spoken with his wife and the resident was receiving foods based on the wife's information. The Dietary Manager met with Resident #95 on 10/1/19, at approximately 4:15 p.m., to obtain preferences directly from the resident. Review of Resident #95's Nutrition assessment dated 9/20/19 revealed the resident was on a regular diet with no restrictions or supplements. It also revealed the resident had no chewing or swallow problems and he fed himself. One of the interventions was to provide meals per the physician's order and to honor the resident's preferences. An interview was conducted with Resident #95 on 10/2/19, at approximately 1: 00 p.m., the resident stated he had received a large salad for dinner on 10/1/19, and lunch 10/2/19, and the Dietary Manager stated the information was on his tray card therefore they will continue to be served until he tells the staff to stop sending them. On 10/3/19, at approximately 6:00 p.m., the above findings were shared with the Director of Nursing and the Corporate Consultant. The Director of Nursing stated Resident #95 should not have had to wait almost three weeks for his food preferences to be obtained and honored and his request should have been passed on to dietary when they were made.	F 806		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations	F 883		11/18/19

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F 883	Continued From page 62 §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative	F 883		

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F 883	Continued From page 63 has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility document review, the facility staff failed to provide the resident or resident's representative education regarding the benefits and potential side effects of influenza immunization for four of 39 residents in the survey sample, (Resident #33, #10, #96, #88). The findings include: 1. Resident #33 was admitted to the facility on 6/2/17 and readmitted on 9/2/19 with diagnoses that included but were not limited to major depressive disorder, bipolar disorder, high blood pressure, and type two diabetes. Resident #33's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 7/25/19. Resident #33 was coded as being moderately impaired in cognitive function scoring 11 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #33's clinical record revealed that she received her last flu vaccine on 10/4/18. The following was documented in her clinical	F 883	1) Resident #33,#10,#88 received education of influenza & pneumococcal immunizations 10/11/19 & resident #26 no longer resides at the facility. 2) Any resident requiring Influenza vaccine here has the potential to be affected by this deficiency 3) In-service education by the DON or designee on the proper form to be filled out and signed for Flu vaccine consent and acknowledgement of education provided to Nursing dept. 4) 100% Audit by the unit mgrs. Or designee of all residents on both units to ensure compliance with proper documentation Weekly audit of new admissions moving forward. Audit results reviewed in QAPI. 5) 11/18/19	

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F 883	Continued From page 64	F 883		

record: "Immunization: Influenza: Consent confirmed date: 10/4/18 Date of Administration: 10/4/18 at 1400 (2:00 p.m.) Route of Administration: intramuscularly Amount Administered: 0.5 ml (milliliters) Location given: Right Deltoid (muscle) Manufacturer's name: Flucelvax..." There was no evidence that education was provided to Resident #33 prior to the administration of the Flu vaccine.

2. Resident #10 was admitted to the facility on 10/27/17 and readmitted on 9/11/19 with diagnoses that included but were not limited to epilepsy, type two diabetes, high blood pressure, heart failure, hemiplegia (one sided paralysis) following stroke and major depressive disorder. Resident #10's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 7/2/19. Resident #10 was coded as being intact in cognitive function scoring 12 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #10's clinical record revealed that she received her last flu vaccine on 10/30/18. The following was documented in her clinical record: "Immunization: Influenza: Consent confirmed date: 10/30/18 Date of Administration: 10/8/18 at 1400 (2:00 p.m.) Route of Administration: intramuscularly Amount Administered: 0.5 ml (milliliters) Location given: Right Deltoid (muscle) Manufacturer's name: Flucelvax..." There was no evidence that education was provided to Resident #10 prior to the administration of the Flu vaccine.

3. Resident #26 was admitted to the facility on 6/4/12 with diagnoses that included but were not

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F 883	Continued From page 65	F 883		

limited to dementia without behavioral disturbance, high cholesterol, type two diabetes and adult failure to thrive. Resident #26's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 7/16/19. Resident #26 was coded as being severely impaired in cognitive function scoring 04 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #26's clinical record revealed that she received her last flu vaccine on 11/5/18. The following was documented in her clinical record: "Immunization: Influenza: Consent confirmed date: 11/5/18 Date of Administration: 11/5/18 at 1330 (3:30 p.m.) Route of Administration: intramuscularly Amount Administered: 0.5 ml (milliliters) Location given: left Deltoid (muscle) Manufacturer's name: Flucelvax..." There was no evidence that education was provided to Resident #26 prior to the administration of the Flu vaccine.

4. Resident #88 was admitted to the facility on 7/13/09 and readmitted on 9/26/12 with diagnoses that included but were not limited to high blood pressure, dementia, and epilepsy. Resident #88's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 9/14/19. Resident #8 was coded as being severely impaired in cognitive function scoring 03 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #88's clinical record revealed that she received her last flu vaccine on 10/22/18. The following was documented in her clinical

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F 883	Continued From page 66	F 883		

record: "Immunization: Influenza: Consent confirmed date: 10/22/18 Date of Administration: 10/22/18 at 1400 (4:00 p.m.) Route of Administration: intramuscularly Amount Administered: 0.5 ml (milliliters) Location given: Right Deltoid (muscle) Manufacturer's name: Flucelvax..." There was no evidence that education was provided to Resident #88 prior to the administration of the Flu vaccine.

On 10/3/19 at 12:00 p.m., RN (Registered Nurse) #1, Assistant Director of Nursing was asked to provide evidence that education was provided to the above four residents prior to receiving the flu vaccination in 2018. RN #1 stated that she was not the nurse in charge at that time but stated that she would look for any education.

On 10/3/19 at 12:12 p.m., RN #1 presented a copy of the education sheets residents received prior to receiving the flu vaccine from the CDC (Centers for Disease Control). RN #1 stated that she could not find evidence that this education was actually provided to these residents prior to administration of the flu vaccine.

On 10/4/19 at 10:46 a.m., during the pre-exit meeting, ASM (administrative staff member) #1, the Administrator, ASM #2, the Director of Nursing and ASM #3, the Regional Director of Clinical Services were made aware of the above concerns.

On 10/4/19 at approximately 11:45 a.m., ASM #2, Director of Nursing presented a "Resident Flu Vaccine Documentation Report" for three of the four residents identified above. This report documented the following: "The facility will keep this record in your medical file. They will record

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F 883	Continued From page 67	F 883		

that vaccine was given, when it was given, the name of the company that made the vaccine, the vaccine's lot number and the signature and title of the person who gave the vaccine. "I have read or have had explained to me the information about influenza and influenza vaccine. I have had the chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or the person named below for who I am authorized to make this request. I also consent to receive annual influenza vaccination from this date forward."

Review of Resident #33's "Flu Vaccine Documentation Report" revealed that she had signed this form on 10/3/17. There was still no evidence that she received education prior to the 10/4/18 administration of the Flu vaccine.

Review of Resident #26's "Flu Vaccine Documentation Report" revealed that her representative had signed this form on 10/29/14. There was still no evidence that she received education prior to the 11/5/18 administration of the Flu vaccine.

Review of Resident #88's "Flu Vaccine Documentation Report" revealed that his representative had signed this form on 10/29/14. There was still no evidence that the representative received education prior to the 10/22/18 administration of the Flu vaccine.

A "Flu Vaccine Documentation Report" could not be provided for Resident #10.

Facility policy titled, "Influenza Vaccine-Resident" documents in part, the following: "Procedure:

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F 883	Continued From page 68 Consent and education for the influenza vaccine will be provided by nursing staff/designee upon the resident's admission to the facility. In the event if a weekend or after hour's admission the admitting nurse will obtain consent and provide education...C. Nursing staff (or designee) will provide the resident and/or resident's representative with information regarding the benefits and potential side effects of the influenza vaccine, every year, in the beginning of September or prior to vaccination...D. Nursing Staff will document the provision if education in the resident's medical record."	F 883		
F 925 SS=F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview it was determined that the facility staff failed to maintain an effective pest control system. The findings included: During the kitchen inspection on 10/01/19 at 11:45 A.M. house flies were observed in the kitchen area. Drain flies were observed in the mop room and dishwasher room. Fruit flies and house flies were observed in the conference room. House flies were observed in the dining room area. Flies were observed on all units. During an interview on 10/03/19 at 2:50 P.M. with the Maintenance Director she stated, the drain flies, fruit flies and house flies have been a	F 925	1. No residents where affected regarding this deficient practice. The Contracted Pest control company was called to the facility and addressed the issue, no further complaints or issues observed. 2. All residents at risk. 3. Contracted Pest Control Company contacted and will formulate a plan with facility Administrator, Maintenance Supervisor, and Housekeeping Supervisor to mitigate the intrusion of any type of fly in facility. 4. Facility will be audited weekly x3months and then quarterly indefinitely for effectiveness of plan. Audits reviewed in QAPI. 5. 11/18/19	11/18/19

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F 925	Continued From page 69 concern and there is a need for pest control. The Maintenance Director stated The Pest Control company came out on 10/03/19 at 11:18 A.M. to service the facility. A copy of the work order was provided by the Maintenance Director. A review of the Pest Management policy indicated: "Mission- We shall first seek to understand the unique needs of each customer, formulate effective solutions, and implement the actions in a timely professional manner." No further information was presented by facility staff.	F 925		